Toward Healthy Cities:
Developing the Relationship Between Municipalities and Regional Health Authorities

Evan Jones
Policy Analyst

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This report was prepared by Canada West Foundation Policy Analyst Evan Jones with research assistance provided by Canada West Foundation Intern Sherri Brown.

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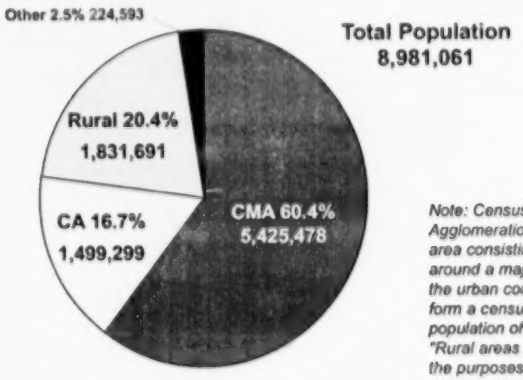
Introduction

Large city-regions are becoming increasingly important to the political, social, and economic fabric of western Canada. It is in city-regions where most western Canadians live and work. It is also where the vast majority of western Canadians receive health care services.

In western Canada, regional health authorities (RHAs) have responsibility for the planning and delivery of regionalized health care services. These are generally core health care services such as hospitals, clinics, and community care, but also include various health promotion activities (Jones and McFarlane 2002). Municipalities are involved in a number of areas that affect the health of the population as well, and urban RHAs tend to have boundaries that correspond roughly to large city-regions. The challenge, then, is for RHAs and municipalities to find practical ways to work together in order to build strong, vibrant, and healthy cities.

How exactly is the relationship between health regions and their corresponding city-regions evolving? What might prevent this relationship from developing, and what can be done to improve it? *Toward Healthy Cities: Developing the Relationship Between Municipalities and Regional Health Authorities* answers these questions in a number of steps. First, the report identifies the current state of health and health-related services in six major western Canadian city-regions: Winnipeg, Saskatoon, Regina, Edmonton, Calgary, and Vancouver. In doing so, the report delineates which services are provided by RHAs, which are provided by municipalities, and which are provided by other bodies such as another regional governance structure. Second, *Toward Healthy Cities* examines the nature of the current relationship between municipalities and RHAs. The interaction of municipal and RHA roles is the primary focus here. Another question to be explored is the extent to which RHAs may become increasingly politicized, through, for example, the

Figure 1: Western Canadian CMA/CA/Rural Population Figures



Note: Census Metropolitan Area (CMA) and Census Agglomeration (CA)are defined by Statistics Canada as: "(an) area consisting of one or more adjacent municipalities situated around a major urban core. To form a census metropolitan area, the urban core must have a population of at least 100,000. To form a census agglomeration, the urban core must have a population of at least 10,000." The term Rural Area is defined as : "Rural areas include all territory lying outside urban areas." For the purposes of this chart, the Other category consists of urban areas not included in CMAs or CAs.

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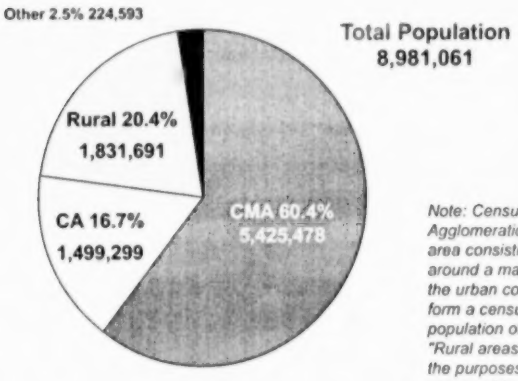

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election of a certain percentage of board members. It is also discussed whether social services should be regionalized in a similar manner to health care. Finally, *Toward Healthy Cities* moves to identify the key barriers to developing municipal-RHA relationships as well as the policies and procedures that work best to foster a positive relationship between RHAs and municipalities.

The following analysis is based primarily on 37 in-depth qualitative interviews with key civic personnel, RHA staff, provincial civil servants, and other persons who either conduct research on or have direct knowledge of the relationships between RHAs and municipal governments in western Canada's major city-regions. Interviews were conducted in February and March 2002. A review of relevant academic, government, and other literature supplemented the qualitative interviews.

Establishing the Context: Urban Health and Wellness

The urban health and wellness model, also referred to as the "healthy cities" model, is a multi-faceted approach that looks at the determinants of health in an urban environment. The World Health Organization (2001) defines the healthy cities model as:

> A long-term urban health and development initiative which aims to improve the health and well-being of people living and working in cities. It is based on a number of key principles: that health should be an integral part of settlements management and development; that health can be improved by modifying the physical, social and economic environment; that conditions in settings such as the home, school, village, workplace, and city profoundly influence health status, and that intersectoral coordination for health is necessary at the local level.

The rationale for approaching health as an urban issue is that for people living in cities to be healthy, the city itself must be a healthy and livable place in which to reside. There are many components to the idea of urban health and wellness which go beyond primary and acute care delivered by hospitals and clinics to include areas such as air quality, water quality, social determinants of health, and other public and population health issues. In short, a well-planned, environmentally sound and prosperous city will almost certainly have healthier residents than its opposite (see Rouyer 2002).

The idea of urban health and wellness fits within a larger approach of looking at health in holistic terms. Research indicates that factors such as a person's natural/physical environment, social environment, and income level all have an impact on their overall health and wellness (World Health Organization 2001). For example, it is well known that people who have lower levels of income and who live in difficult social circumstances are far more likely to experience poor health than those with higher levels of income and stable social circumstances. (See, for example, Health Canada 2002).

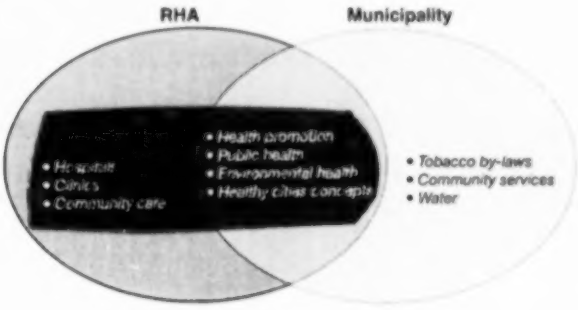
According to the 2001 census, 79.4% of Canadians now live in urban centres of 10,000 or more (Statistics Canada 2002), and the delivery of most specialized health care and related services is in urban centres. In addition to RHAs, which administer direct health care services such as hospitals and clinics as well as having a health promotion role, municipal governments have a strong role to play in contributing to the health of their residents. Indeed, one respondent for this study estimates that municipal governments are responsible for between 20 and 25 percent of what influences population health. Some specific examples of areas typically under municipal jurisdiction that impact population health include smoking by-laws, water supply, certain aspects of public/environmental health, and various community services.

Who does What: Municipal–RHA Intersections

Before examining the relationship between municipal governments and RHAs, it is crucial to be clear on the extent to which their policies and services intersect. Which health services are delivered by RHAs? Which health services are delivered by municipalities? To what extent do RHAs and municipal governments provide complimentary services or joint services?

This section answers these questions for Winnipeg, Saskatoon, Regina, Edmonton, Calgary, and Vancouver, based primarily on the experiences and perceptions of the 37 respondents. The discussion of services here is not intended to be exhaustive, but does provide a solid overview of what is happening with the provision of health and health-related services in the six city-regions. It should be noted that at the time of the researching of this report, Saskatchewan was undergoing a move from 32 health districts to 12 RHAs. For

Figure 2: A Conceptual Model of Overlapping Municipal and Regional Health Authority Responsibilities



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Where Are the Municipal-RHA Intersections?

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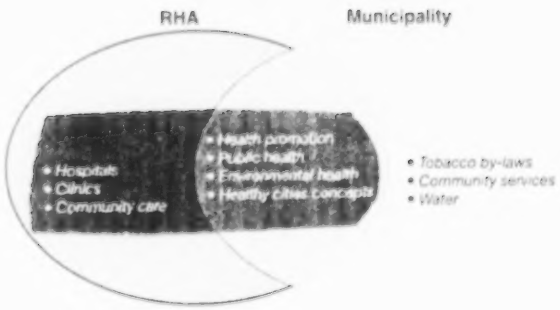

this reason, the information presented below is based on respondents' experiences with the Saskatchewan health districts prior to recent restructuring initiatives.

Winnipeg

The Winnipeg Regional Health Authority (WRHA) is responsible for the planning and delivery of regionalized health care services in the Winnipeg city-region. In the past the City employed a medical health officer and provided certain public health services, but these are now provided by the WRHA. The City still provides public and environmental health inspection services in areas such as food and housing, but this may at some point be transferred to the WRHA as well. Another area of municipal-RHA intersection is recreational and leisure services, and joint committees between the City and WRHA have been established as needed to work on specific programs. At present, the City provides ambulance services, but there is ongoing discussion on this matter. Municipalities just outside the city contract with Winnipeg for ambulance service. As in many other cities, tobacco by-laws are an area of policy that, though passed by the City, have a definite impact on the RHA. There is also a fair amount of interaction between community services provided by the City and health services provided by the WRHA. There is some joint programming between library services and the WRHA regarding information for new parents, and both the City and WRHA are involved in the City's disaster response plan.

Saskatoon

Saskatoon District Health (SDH) is responsible for the planning and delivery of regionalized health care services in the Saskatoon city-region. However, there are a number of health-related programs that are jointly funded with the City of Saskatoon. For example, there is the "In Motion" program, a joint program between the City and SDH that encourages people to be active and healthy. Another program with RHA and municipal involvement is the "child friendly" program, which identifies businesses deemed to have practices friendly to children and encourages partnerships with these businesses. SDH has a strong interest in the urban planning of Saskatoon, particularly as it relates to having outdoor recreation space, and SDH tries to influence the City in this area. There is also a youth centre and a planned detox centre, both of which have municipal and health district involvement, as does social housing. Transportation services for disabled individuals are the responsibility of the City, though as in Regina, this is an area of some contention. Ambulance services are provided by the health district on a contracting-out basis, and 9-1-1 and tobacco by-laws are the responsibility of the City. Additional areas of common interest and intersection cited by respondents include drinking water, sewage, industrial pollutants, and housing/building safety.

Regina

The Regina Health District (RHD) is responsible for the planning and delivery of regionalized health care services in the Regina city-region. Areas of policy and service intersection with the City of Regina include

a general interest in community well-being, public and environmental health, waste management, children and seniors, drug addiction, and an Aboriginal health strategy that is run by the RHD but which the City has an interest in. Public health in the past was a City responsibility, but it is now under the authority of the RHD. One area of joint responsibility is the Pioneer Village senior citizens facility that is owned by the City but operated and funded by the RHD. The City remains responsible for capital infrastructure costs and accrued debt for the facility, and it was reported that the facility currently needs renovation but the City does not have the money to finance this.

One respondent stated that the most important intersection between the City and the RHD was in the area of waste management, due in part to the fact that the RHD produces a large amount of bio-medical waste of which the City is responsible for disposing. In other areas, the City is responsible for

Figure 3: Regional Health Authority Boundaries and Populations

	Municipalities Included in the Regional Health Authority
Winnipeg City of Winnipeg = 619,544 Winnipeg CMA = 671, 274	• **Winnipeg Regional Health Authority (646,733):** Winnipeg, East St. Paul and West St. Paul.
Saskatoon City of Saskatoon = 196,811 Saskatoon CMA = 225, 927	• **Saskatoon District Health (242,000):** Saskatoon and 50+ rural and urban communities of varying size.
Regina City of Regina = 178,225 Regina CMA = 192,800	• **Regina Health District (213,000):** Regina and 55 other cities, towns, villages and rural municipalities.
Edmonton City of Edmonton = 666,104 Edmonton CMA = 937, 845	• **Capital Health Authority (827,507):** Edmonton, St. Albert, Strathcona county, Leduc county.
Calgary City of Calgary = 878,866 Calgary CMA = 951,395	• **Calgary Health Region (989, 015):** Calgary, Airdrie, Beiseker, Chestermere, Cochrane, Crossfield, Irricana, Municipal District of Rocky View.
Vancouver City of Vancouver = 545, 671 Vancouver CMA = 1,986,965	• **Vancouver Coastal Health Authority (1 million):** Vancouver, Richmond, West Vancouver, City and District of North Vancouver, Ambleside, Deep Cove, Lions Bay, Bowen Island, Lund, Powell River, Saltery Bay, Pender Harbour, Sechelt, D'Arcy, Pemberton, Whistler, Squamish, Lions Bay, Horse Shoe Bay, Texada Island, Gibsons, Toba, Bella Coola, Bella Bella. • **Fraser Health Authority (1.3 million):** Abbotsford, Anmore, Belcarra, Burnaby, Chilliwack, Coquitlam, Delta, Harrison Hot Springs, Hope, Kent, Langley, Langley Township, Maple Ridge, Mission, New Westminster, Pitt Meadows, Port Coquitlam, Port Moody, Surrey, White Rock.

Source: Communication with RHAs, on-line RHA material, and Statistics Canada.

tobacco by-laws, though the most recent tobacco by-law was also endorsed by the RHD. Ambulance services are provided by the health district, but transportation for the disabled and 9-1-1 dispatch are both the responsibility of the City. The issue of who should fund transportation for the disabled in Regina is one of some controversy. At one point the City sent the health district a bill for $400,000 for this service, and subsequently the two parties agreed to consult the Province over who should be responsible for this service.

Edmonton

The Capital Health Authority (CHA) is responsible for the planning and delivery of regionalized health care services in the Edmonton city-region. Areas of common interest with the City of Edmonton include population health, drinking water (provided by EPCOR), transportation planning, policing, and tobacco by-laws. Social services and housing policy were identified as municipal policy areas that have an impact on population health. The City of Edmonton is responsible for providing ambulance service within its boundaries, but this is currently under discussion, and ambulance service may at some point be transferred to the CHA. In terms of urban planning, the City of Edmonton has a relationship with the CHA in regards to where new health facilities will be located and the transportation access to those sites.

Calgary

The Calgary Health Region (CHR) is responsible for the planning and delivery of regionalized health care services in the Calgary city-region. Perhaps the most obvious service intersection between the City of Calgary and the CHR is in the area of Emergency Medical Services (EMS), which includes ambulance service. EMS is presently provided by the City, although as in Edmonton this is under discussion and it is possible that at some point in the future this responsibility could be transferred to the CHR. Other services run by the City but which are related to health are water supply, contaminated sites issues, and transportation planning, especially where proper access to health facilities is concerned. A general concern with urban planning as it relates to health promotion and wellness was also cited by respondents, especially in regards to parks and recreation services provided by the City, although such planning is not necessarily discussed with the CHR.

There are some health-related community and social services run by the City of Calgary, as well as some joint programs run by both the CHR and the City. For example, there is an on-line directory known as "informcalgary.org" run by both the City of Calgary and the CHR that is intended to facilitate the dissemination of information about various health, community and social services in the Calgary area (Informcalgary.org 2002). The existence of such a resource shows the important relationship between community and social services provided by municipal governments and health services provided by RHAs. The downtown CUPS (Calgary Urban Project Society) Community Health Centre, which is a community social service funded by the City of Calgary and the CHR and which is intended to assist at-risk, vulnerable

Figure 4: Common Health Care Related Services and Providers

Service	Winnipeg	Saskatoon	Regina	Edmonton	Calgary	Vancouver
Ambulance	City	RHA	RHA	City	City	Province
911 Service	City	City	City	City	City	GVRD
Transportation for the Disabled	City	City	City	City	City	Translink
Public/ Environmental Health	RHA/City	RHA/City	RHA/City	RHA/City	RHA/City	RHA
Community Services	City	City	City	City	City	City
Tobacco By-laws	City	City	City	City	City	City
Water	City	City	City	City (EPCOR)	City	GVRD

Source: Qualitative interviews and on-line material.

persons, has an on-site health clinic run by the CHR that is specially designed for this population. Other joint programs include the "Street Esteem" project, which is designed to look at the overall social well-being of the homeless population, a planned 211 project, which will be a 24 hour information/referral telephone database system, and the now completed Elder Friendly Communities Project, which looked at the needs of senior citizens.

Vancouver

The Vancouver Coastal Health Authority (VCHA) and Fraser Health Authority (FHA) are responsible for the planning and delivery of regionalized health care services in the Vancouver city-region. There are a number of bodies involved in Vancouver-area health and health-related services, including the VCHA, the FHA, the Greater Vancouver Regional District (GVRD), Translink (the Greater Vancouver Transportation Authority), and the provincial government. The GVRD handles health-related services such as drinking water, air quality, sewage, garbage, and 911 service (GVRD 2001). Translink handles health related services such as vehicle emissions, transportation for the disabled, and regional transportation planning (Translink 2001).

Because of the recent establishment (December 2001) of the VCHA and FHA, there is some uncertainty as to the nature of the intersections between municipalities and the new RHAs. There were numerous points of intersection in policies and services mentioned between the City of Vancouver and the former Vancouver/Richmond Health Board (VRHB), and it is anticipated that there will be a similar relationship between the City of Vancouver and the new VCHA. At a very basic level,

Figure 5: Joint Municipal-RHA programs and Services Reported by Respondents

	Programs and Services
Winnipeg	• Recreational and leisure services (joint City-WRHA committees established as needed) • Information for new parents (WRHA and Library services) • Disaster response plan
Saskatoon	• In motion program • Youth centre • Detox centre (in planning stage) • Social housing • Child friendly program
Regina	• Pioneer Village senior citizens facility
Edmonton	• None reported
Calgary	• Informcalgary.org • CUPS • Street Esteem • 211 (in planning stage) • Elder Friendly Communities Project (now completed)
Vancouver	• Programs and services under the Vancouver Agreement

Source: Qualitative interviews

both the City and the VCHA are concerned with the well being of Vancouver residents. Direct areas of intersection noted include housing policy, population health, and child/youth issues. The Vancouver Agreement (discussed in the next section) provides the framework for many such intersections. Ambulance services in the Vancouver region are currently provided directly by the Province. At the time of the interviews for this study, sources stated that there was a projected budget shortfall in the VCHA of between $120 and $150 million. Such a shortfall could very well have direct impacts on the City of Vancouver, as any reductions in services by the VCHA will affect residents of the city. It may also put additional pressures on services provided in tandem with the VCHA.

Summary

Across the six cities, it was found that there are numerous instances where municipal governments and RHAs provide services that are complimentary to one another, as well as cases where projects are jointly funded and administered by municipalities and RHAs. In many instances, municipal policy is understood to have an impact on the health of a given population, and hence an impact on the corresponding RHA. Policy and service intersections are common in areas such as tobacco by-laws, water, environmental/public health, and community services. In some instances, urban planning was cited as relevant to health in terms of the promotion of a healthy city. Urban planning involves land use, transportation design, and the creation of outdoor recreational spaces, all of which can affect the overall health of the population. By focusing on well-planned cities with a stable physical, social, and economic environment, municipalities can have an important impact on population health. RHAs can increase their own impact by communicating with municipalities on these issues.

The Current State of Municipal--RHA Relationships

Given the many points of intersection and common interests between RHAs and municipal governments, one might expect formal governance structures, such as joint committees. However, this assumption is found to be true in only a few cities. While a relationship between RHAs and municipal government exists in each of the six city-regions, the nature of these relationships varies between formal and informal, and between established and ad hoc.

Winnipeg

Respondents report that while the WRHA and Province have a close relationship, the WRHA and City of Winnipeg tend to operate in isolation from one another. The relationship is described as "positive" and "supportive," but "somewhat distant." However, there is an openness to the idea of more cooperation and formalized communication. Currently, personnel in the two organizations meet as required, and this works fairly well, but there is a desire to make this more of a regular and ongoing affair. An ideal relationship, respondents suggest, might consist of a joint standing committee composed of municipal and WRHA personnel. The key barriers to developing this relationship any further are the constant pressures with which the WRHA is faced - one respondent stated that the WRHA survives on a "minute to minute basis."

The WRHA and the City of Winnipeg's Community Services department do have some shared office space in certain neighbourhoods, and this helps to facilitate the sharing of information. There is a joint commitment to neighbourhood-based services, and though it was stated that the two organizations are somewhat isolated from one another, it was thought that once a high-level agreement in principle, currently being negotiated, is put in place between the WRHA and City, this will result in a more coordinated relationship.

Saskatoon

Respondents stated that there was an informal relationship between the City and SDH, but that it was working well. Regular communication takes place between certain personnel in both organizations. The relationship was described by one respondent as "very good," but not quite "excellent." It was noted that there is a willingness from both parties to get involved in joint projects, although at times limited resources, both human and financial, are a barrier to such projects.

It was thought that the SDH board and city council, and the SDH board chair and mayor, should probably communicate more regularly. Semi-annual meetings between the two organizations were suggested as a way to go about doing this. One negative aspect of the relationship that was identified was a tendency to off-load certain problems onto the other party or wait until the other party does something about a certain issue or problem. This situation was again blamed on the limited resources available to both organizations.

The municipal-health district relationship is likely to become more complicated in the near future. The reason for this is that in addition to having boards that are entirely appointed by the Province, the new Saskatoon RHA will encompass municipalities much further away from Saskatoon than were included in the former SDH. The new RHA will have to develop relationships with these municipalities, and this may present new challenges for the organization.

Regina

There are a number of committees made up of such organizations as the health district, the City, and the police, but these are established as needed and are time limited. The relationship between the RHD and the City is reported to be "okay" and "improving," but it was noted that the past relationship was not characterized by cooperation and that more trust needs to be built. The relationship at the staff/operational level is working quite well, but the further development of this relationship is somewhat hampered by a lack of coordination among upper administrative personnel.

Strengths in the relationship include a good recognition of common objectives and interests, and meetings between the health district CEO, the city manager, and the mayor, as well as joint city council-health board meetings at least once per year. In some instances, RHD board members have sat on city committees. One respondent stated that the relationship between the City and the RHD is in fact good, and that one of the strengths of the relationship is collaboration at the political as well as the operational level. In general, there needs to be an ongoing awareness of the importance of the relationship between the two parties. It was thought that improving the relationship between the City and RHD would "absolutely" benefit residents through the development and delivery of services that are more responsive to the needs of the population.

Edmonton

Unlike most other cities, it was reported that there is a quite formal relationship between the CHA and the City of Edmonton. There is a joint CHA-municipal advisory committee that meets monthly or as required. On this committee are four CHA board members and two representatives, usually aldermen, from each of the CHA area municipal governments. These meetings typically result in the exchange of information and sometimes joint initiatives. In addition, there are regular CHA board meetings every two months to which local mayors will come if there is an issue they are concerned about, as well as a committee of the whole that includes mayors and that meets every two months. There are also meetings that occur as they are needed among various personnel. One respondent stated that the relationship between the CHA and municipalities in the region is working "very, very well" and listed good communication as a key strength to this relationship. However, it was also noted that it would be easier for the CHA to deal with one municipal government instead of four. Another respondent stated that there could be a more formalized sharing of information regarding the goals of the respective organizations and more formalized discussions

of the implications of certain policies. Yet another respondent stated that the City could receive more input from the CHA on urban planning and urban health.

An important problem noted is that there is currently a "very unworkable" health authority boundary in place for the CHA. Specifically, it was noted that major suburbs such as Stony Plain and Spruce Grove as well as the County of Sturgeon are not currently included in the CHA but should be in order to facilitate planning at the regional level. Another recommendation for improvement was to put a greater emphasis on community health and wellness, which is an area that the City and CHA should work collaboratively on.

Calgary

One respondent stated that there was a relatively good working relationship between the City of Calgary and the CHR, and another described it as "a growing relationship" with opportunities to work together on areas such as wellness and health promotion. City councilors for Calgary as well as other town councils in the CHR meet with CHR board members on an annual or bi-annual basis. In some instances, staff offices for the City and CHR are located side-by-side. As well, CHR officials will meet as needed with city planning department personnel regarding new health facilities to discuss issues such as the location of facilities and transportation access. In short, there is a sharing of information at the operational level between the City and the CHR.

It was noted by one respondent that both formal and informal relationships exist, and that the relationship is "straight forward." One respondent felt that there could be more opportunities for dialogue between CHR board members and city councilors, and an increased understanding of the common goals and constraints facing the CHR and City. Respondents identified a lack of resources as being one of the primary barriers to further developing this relationship.

Vancouver

While it is unclear at this time what the relationship between the City of Vancouver and the new VCHA will be, in the past the City had a positive though possibly underdeveloped relationship with the VRHB. On some key issues, "everyone was at the table," as one respondent noted. However, there still existed some unclear lines of accountability and responsibility. There was a lack of certainty over who had the mandate for certain policies - the Province, the RHA, or the City. It was mentioned by another respondent that the new structure of five large RHAs in British Columbia, two of them in the lower mainland, will make relationships with municipalities more difficult - at least in the short term. Strategies for communication between the five large RHAs and municipal governments will need to be developed given the recent health care restructuring in BC. Budgetary pressures that the VCHA is facing may also have adverse impacts on the relationship between the City and the VCHA. For example, a VCHA budget deficit may limit or eliminate opportunities for VCHA involvement on projects that the City and VCHA might work on together.

The current VCHA-City of Vancouver relationship appears to be off to a good start. One respondent described the relationship between the City of Vancouver and the VCHA as "really good." This relationship has been formalized somewhat by the Vancouver Agreement (discussed below). There are meetings that occur as required between VCHA officials and municipal officials (such as the city manager and mayor of Vancouver); respondents felt it is possible that the meetings could be formalized to a greater degree in the future. One respondent suggested that the VCHA should consult with other stakeholders beyond the level of municipal government.

One example of intergovernmental cooperation is the Vancouver Agreement, which involves the federal, provincial, and Vancouver municipal governments. The purpose of this agreement is to promote and support the "sustainable economic, social and community development of the City of Vancouver, focusing initially on the area known as the Downtown Eastside" (Vancouver Agreement 2000). Vancouver's Downtown Eastside is an area known for its poverty, crime, prostitution, drug use, and high HIV/AIDS infection rates. A representative from the VCHA is among the provincial delegates appointed to the Management Committee for the Vancouver Agreement. Health issues involving multi-party cooperation are of central importance to the agreement, and the agreement states that "Effective linkages between health care and social services programs will be promoted" (Vancouver Agreement 2000).

There is also a relationship between the GVRD and the VCHA and FHA. There has not been a direct funding relationship since 1999 when regional hospital funding in the GVRD was taken over by the Province, but there is still a formal relationship regarding the monitoring of air and water quality between the GVRD, the municipalities, and the two medical health officers that work for the VCHA and FHA. There was a concern expressed by one respondent that the boundaries of the VCHA and FHA are not entirely logical as they artificially divide the GVRD in two. It was proposed that a Greater Vancouver Health Authority with boundaries co-terminus with the GVRD would make more sense. It was also expressed that a dialogue between the heads of the two RHAs and the GVRD would benefit residents of greater Vancouver, and that the boundaries of the RHAs as they exist now are a barrier to developing this relationship.

Summary

Speaking to the Edmonton experience, one respondent stated that it would be "unthinkable" that the CHA and City of Edmonton would not have a formal relationship, and that without such formalized communication many important issues might be neglected. In some cities, such as Edmonton, the relationship between RHAs and municipalities is highly formalized. In other cities the relationship is much more limited and what does exist is largely informal. Given that municipal governments and RHAs have the ability to positively impact population health through the utilization of concepts such as the healthy cities model, regular communication between RHAs and municipalities should result in more coordinated policy and service delivery, thereby increasing this impact. For this to work there needs to be a clear understanding of the responsibilities of the respective bodies as well as a shared vision of the ends both are trying to reach. This

Figure 6: Municipal–RHA Relationships

	Formal RHA-City Relationships	Informal RHA-City Relationships
Winnipeg	• Agreement in principle being negotiated that should help relationship	• Meet as required • Some shared office space
Saskatoon	• Some joint programming	• Regular communication
Regina	• Joint ad hoc committees • Joint city council-health board meetings at least once per year • In some instances RHD board members have sat on city committees	• Good working relationship at staff/operational level
Edmonton	• Joint CHA-municipal advisory committee • Mayors invited to CHA board meetings • Committee of the whole	• Meetings as needed
Calgary	• Annual or bi-annual CHR–municipal council meetings	• Staff offices located adjacently • Meetings as needed • Sharing of information at operational level
Vancouver	• Vancouver Agreement • Relationship regarding air and water quality between GVRD, municipalities and VCHA/FHA medical health officers	• Meetings as needed

Source: Qualitative interviews

will likely involve joint projects and policy development as well as a regular exchange of information and ideas between RHAs and municipal governments.

Political Role of RHAs

Respondents for this study were asked to consider the potential political role of RHAs. There were a variety of views on whether RHAs in different cities could or should become political actors. One commonly stated determinant of this potential politicization was whether the RHA was elected or appointed. Many thought that a partially elected board stood a much greater chance of becoming a political entity with a democratic mandate than an RHA board strictly appointed by the provincial government, although it is important to note that provincial appointments may themselves be political and partisan in nature. Generally, opinion was split as to whether boards should have elected members or not. Proponents of elected board members emphasized greater community input into the board's decisions, whereas detractors felt that there would be unnecessary conflict produced and that it would be more difficult to accomplish important tasks.

There are two types of RHA boards in western Canada: those that are entirely appointed and those that are partially elected. In cases where RHA boards are entirely appointed, which includes Vancouver and Winnipeg and (under the new changes) Saskatoon and Regina, respondents generally felt there was less chance of a political role. For example, one Vancouver area respondent stated that an appointed board functions more like a corporation than a political entity, but that in the past the former VRHB did take some

positions that bordered on political. There was also a strong partisan connection mentioned in regards to the VRHB's relationship with the previous provincial government. Specifically, the VRHB allegedly never balanced its budget because it knew it would be "bailed out" by the provincial government because of this partisan connection. In the case of Winnipeg it was felt that the WRHA stands less chance of becoming a political actor so long as the board is appointed. However, it was also stated that because of its large budget (at $1.2 billion the WRHA consumes approximately half of the Manitoba health budget) and its ability to influence other actors (such as on tobacco by-laws), the WRHA is already a political actor.

In city-regions where boards are partially elected, which includes Calgary, Edmonton, and (before recently made changes) Saskatoon and Regina, it was generally felt that there was a greater chance of a political role being taken. In the case of Alberta, as of October 2001 two-thirds of RHA board members are elected. RHAs in Calgary and Edmonton may be far more likely to become political actors now that elected members can claim a democratic mandate from local constituents. However, similar to what a Vancouver-area respondent said, a Calgary respondent stated that board members are more likely to behave like a "board of directors" than as elected politicians, and that there is far less chance of the type of political "grandstanding" going on in RHAs than occurs in city council. In Edmonton it was noted that since the CHA board has become partially elected, "dynamics have changed." Specifically, elected members tend to be more aggressive on certain issues and there is generally an increased amount of discussion now that there are ten elected members on the CHA board.

Before the Saskatchewan provincial government announced its plans to move down to 12 RHAs that are entirely appointed, there were 32 partially elected District Health Boards (DHBs). One good example of a Saskatchewan health board taking on a political role was when SDH advocated for an increase in the provincial minimum wage as a progressive move related to the social determinants of health. One issue that came up in Saskatoon was whether the provincial government realized that by regionalizing health care it would possibly be creating independent political actors with independent planning capabilities. It

Figure 7: Elected and Appointed RHAs

	Elected/Appointed
Winnipeg	Appointed
Saskatoon	Was partially elected, under new plan will be entirely appointed
Regina	Was partially elected, under new plan will be entirely appointed
Edmonton	Two-thirds elected
Calgary	Two-thirds elected
Vancouver (VCHA and FHA)	Appointed

Source: Jones and McFarlane 2002.

might be questioned, in light of this, whether the move to appoint all board members under the new RHA structure is partially an attempt by the Province to assert political control over the boards. In Regina it was stated that it is natural for health boards to become politicized given their large budgets and the high public interest in health care, and that in fact Regina's health board members "are [already] political actors."

Overall, there was a wide range of opinion across the West as to whether RHAs have, could, or should become political actors. Some felt that due to their role as governance bodies with large budgets and the political nature of health care, it was inevitable that there would be some politicization of RHAs. Others felt that such politicization was inappropriate, that RHAs should focus on service delivery, and that voter turnout was too low for board members to have proper democratic legitimacy. Given the wide range of opinions expressed on this matter, it is difficult to draw general conclusions. The political aspect of RHAs is something to be watched as provinces continue to experiment with the size and structure of their health regions.

Building The Relationship: Key Lessons

Canada West's research found that regular, meaningful communication between municipalities and RHAs, both formal and informal, was the key to building a solid relationship. Such communication is likely to result in more coordinated service delivery and even formalized joint initiatives. Where municipalities and health authorities are able to identify their common goals and interests, the results will almost certainly be better for everybody, including the residents of the city-region.

Explanations for Undeveloped RHA-Municipal Relationships

Why wouldn't RHAs and municipalities communicate regularly, either formally or informally? In answer to this, the research established two general explanations.

Lack of Resources

Time and money are in short supply, and both RHAs and municipalities find themselves facing significant cost pressures and tough decisions that require immediate action. One result of this, as reported in Saskatoon, is that RHAs and municipalities may off-load their problems and responsibilities onto the other or wait for the other to address a particular issue. Another result of the lack of financial and human resources is that communication between the two organizations suffers because it is simply not as high a priority as, say, budget deficits. It was expressed by respondents that no one wants to have a meeting just for the sake of having one, especially when there are items of much greater importance on the agenda.

Although it is understandable that short-term crises must be dealt with swiftly, municipalities and RHAs need to recognize that by cooperating more extensively, this should in the long run result in a healthier population

Social Services and Regionalization: The Next Step?

It is possible that the regionalization of health services may carry with it some lessons for the social services sector. As noted in Jones and McFarlane (2002), British Columbia, Saskatchewan, and Manitoba each have regional approaches to the delivery of social services, but at this time only Alberta has truly regionalized planning and decision-making through the establishment of 18 Children and Family Services Authorities (CFSAs). Seventeen of these CFSAs have boundaries co-terminus with the seventeen provincial RHAs (the eighteenth CFSA is composed of eight Metis settlements). These CFSAs are governance structures similar to RHAs that possess the capacity to engage in resource allocation decision-making.

At least one other western province, British Columbia, is looking to regionalize the planning and delivery of social services. The BC Ministry of Children and Family Development states that Over the next few years, new service delivery models and reductions in the overall ministry budget will result in FTE [full-time equivalent] reductions and devolution of specific services and resources, including staff, to community governance structures (BC Ministry of Children and Family Development 2002). While the BC government s intent to regionalize is clear, its rationale for doing so is less obvious. One might ask whether such restructuring is aimed at providing better services and planning, or rather as a way for the government to distance itself from unpopular cuts to services. These same questions have been raised in regards to the rationale for health care regionalization in the western provinces (see Jones and McFarlane 2002).

Do respondents think the regionalization model should be expanded to social services? As with the question of whether RHA boards have, could, or should become political actors, the question whether the regionalization of social services is a good idea garnered wide-ranging responses. There was a general consensus that if social services are regionalized, the boundaries of the new authorities should be co-terminus with existing RHA boundaries. In the case of Alberta there is some joint programming that takes place with RHAs and CFSAs, and this is facilitated by having co-terminus boundaries. It was also noted that there are relationships between CFSAs and municipalities, and one respondent stated that in Edmonton the relationship between the City and CFSA was more direct than between the City and RHA. Another respondent said that it would make sense for school districts to have co-terminus boundaries with social services and health care, and that having different boundaries breeds inefficiency.

Another option for regionalizing social services would be for RHAs themselves to take over social services. It was thought that this might increase service integration and coordination, and one respondent suggested that RHAs might need to take on social services because this may be the only way social services get properly funded. Others felt that this was not a good option, and that there needs to be a separation as the two areas are in fact different. There is also a risk that by taking on social services RHAs could become larger than desirable bureaucracies. A possible compromise position may be the view of one respondent who felt that there needs to be a separation of services, but a coordination of service delivery.

and therefore lower costs in areas such as acute care and ambulance services. Nevertheless, it also needs to be recognized that ***if municipalities and RHAs are expected to communicate and cooperate, they need to be given the financial and human resources to make this possible.*** Otherwise, an imminent ER closure in a local hospital will always take precedence over a joint committee of some kind.

Geographic Boundaries

Another barrier to developing the municipal-RHA relationship that was cited by respondents is the way RHA and municipal boundaries are drawn. In both the Edmonton and Vancouver city-regions it was reported that the RHA/municipal boundaries are a problem in their current form and make regional planning more difficult. In the Edmonton case this is because there are suburban areas of Edmonton that are not included in the CHA, and in Vancouver it is because the VCHA and FHA effectively divide the greater Vancouver region in two. ***Proper regional planning requires that policy-makers look at the linkages between municipalities in a large city-region and draw boundaries accordingly.***

Essential Components of a Developed RHA-Municipal Relationship

Three broad themes emerged from the research as being essential to the building of a good relationship between RHAs and municipalities.

Recognition of Common Goals

One key lesson learned is that municipalities and RHAs need to recognize that, at least in theory, their end goals – the overall well-being of the community – are very similar if not identical. A specific example of this would be in Saskatoon where it was stated that both the health district and municipal government have developed an increased awareness of the determinants of health for their population, and the role each party plays in this regard. ***RHAs and municipalities should familiarize themselves with their respective long and short-term goals, and recognize their similar mandate for having a healthy population.*** This should be based on the principles of urban health and wellness.

On-going Communication

It was stated by one respondent that "the doors of communication are open" - this is a key component of further strengthening the municipal-RHA relationship. The importance of regular communication at the administrative level as well as at the health board-city council and staff/operational levels was also identified as an important lesson learned. An ideal scenario cited by one respondent would be a situation where there is an on-going dialogue between RHAs and municipalities with a plan as to the direction their policy should take, and the ability to fund this plan. One respondent concluded that when public sector organizations work collaboratively, "everybody wins." RHA and municipal officials, particularly on the administrative side, should continue to work together to foster a strong relationship through the recognition of their common goals. It is especially important for administrators in each organization to work together because they tend to be the individuals who develop specific policies, programs, and services.

Formal Mechanisms

While it may not be necessary or desirable to have formalized structures between RHAs and municipalities in every case, there are advantages that formalization brings. Through the process of working together on a regular, formalized committee, municipalities and RHAs are engaging in a type of relationship building that may not be possible through ad hoc relations alone. In Vancouver, for example, the Vancouver Agreement provides a mechanism for the RHA (as a representative of the province) and the municipal government to work together as well as with the federal government. The proposed agreement in principle between the City of Winnipeg and the WRHA, which will formalize common goals and interests and help to facilitate better service coordination, is another example of formalization that should help to build the municipal-RHA relationship. Yet another relationship building exercise cited by one respondent is the importance of RHAs and municipal governments continuing to work together on joint projects. One area for improvement that was identified by a respondent is that there could be a better "early warning system" put in place to identify potential problem areas in the municipal-RHA relationship - doing this might involve some type of formal structure as well.

There should, at a minimum, be a formalized annual or bi-annual meeting between RHA and municipal personnel, including RHA board members and city councilors, to discuss their short and long-term goals and to discuss and develop a plan as to how to collaboratively reach those goals. Joint RHA-municipal initiatives and projects should also be encouraged.

Conclusion

Health care continues to be a pressing issue of both regional and national importance. While news headlines tend to focus on direct health care services or controversial topics such as privatization, there has been a growing trend for some time now that looks at health in more holistic terms, focusing especially on the determinants of health. This is one of the areas where the municipal government-RHA relationship has the most impact. By focusing on the idea of urban health and wellness - meaning city-regions with strong economies, proper planning, high quality health care and social services, strong social cohesion, and that are environmentally sound and sustainable - municipal governments and RHAs have an opportunity to positively affect the health of their residents. In order to accomplish this it is imperative that the two organizations maintain an open dialogue and on-going communication, acknowledge their common goals and interests, and are willing to cooperate to realize those goals and interests. Much of this is already happening in city-regions across western Canada, but there have also been areas identified where improvement is needed. By working collaboratively, municipal governments and RHAs have the potential to create the kind of healthy, vibrant cities that are essential to the contemporary urbanized economy. ■

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